

# Minimising The Unintended Consequences Of Opioid Treatment: Development Of An Australian Aberrant Drug Behaviour Scale

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## Introduction

A large body of literature from the United States describes aberrant (i.e. use other than as prescribed) medication-related behaviours among pain patients, and the extent to which they are associated with harm (1-4). To date, these clinical tools have not been tested and validated in Australian clinical populations. This paper (i) reviews the aberrant drug behaviour literature and (ii) describes the development of an aberrant drug behaviour scale for use in multiple healthcare settings in Australia.

## Method

The present study has two stages.

Stage 1: N=39 key experts (KEs) have been recruited since May 2011. Nationwide representation from pharmacies, emergency departments, allied health, mental health, general practice, palliative care, opioid substitution treatment (OST), pain treatment services, researchers in these areas and consumer representatives were sought. These surveys are being used to inform the development of a brief scale (10-20 items).

Stage 2: The latent structure of the proposed scale, and its construct validity and (inter-rater, test-retest) reliability will be examined using interview data from N=400 adult chronic opioid treatment patients.

This poster presents some of the findings from the Key Expert Survey.

## Results: Literature Review

A search of the literature identified 26 scales, each of which varied in terms of their aims, administration and/or scope. None had been tested in Australian populations.

These scales included:

**ABC** (Wu et al., 2006); **ABQ** (Passik et al., 2000); **COMM** (Butler et al., 2010, 2007); **DIRE** (Belgrade et al., 2006); **ORT** (Webster and Webster, 2005); **PADT** (Passik et al., 2004); **PDUQ** (Compton et al., 1998, Miotto et al., 1996); **PMQ** (Adams et al., 2004, Holmes et al., 2006); **PODS** (Banta-Green et al., 2010); **Physician Questionnaire on Aberrant Drug Behavior** (Michna et al., 2004); **POMI** (Knisely et al., 2008); **Prescription Opiate Abuse checklist** (Chabal et al., 1997); **SISAP** (Coombs et al., 1996); **SOAPP**; **SOAPP-R** (Butler et al., 2004, 2008, 2009); **STAR** (Friedman et al., 2003)

Variety in aims:

- Generally scales focused on predicting risk of dependence
- Measure current behaviours

Variety in administration:

- Direct questioning of patient
- Clinician-completed scale
- Criteria for clinician to consider when reviewing patients

Variety in scope:

- 'Aberrant' behaviours, e.g. stockpiling medication, calling in at emergency departments, requesting early script renewals
- Structural/social determinants, e.g. legal problems, employment, age, social environment
- Comorbidities, past or current substance abuse, mental health
- Functioning, e.g. wellbeing, anger

Problems with these scales:

- Not appropriate for the context, e.g. Identified behaviours that may not be relevant to the Australian population
- Too long
- Aiming to predict dependence rather than identify current problems/behaviours (our aim)

Decision:

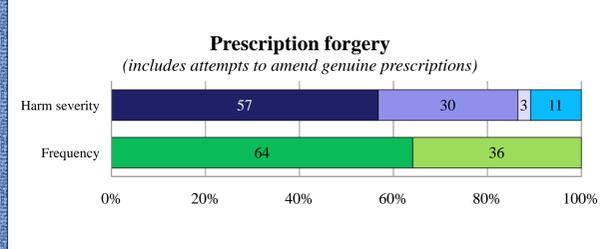
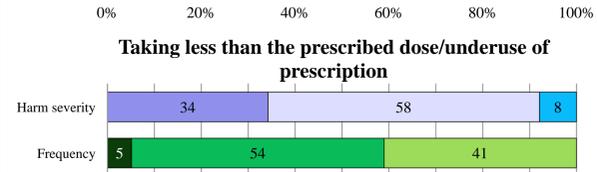
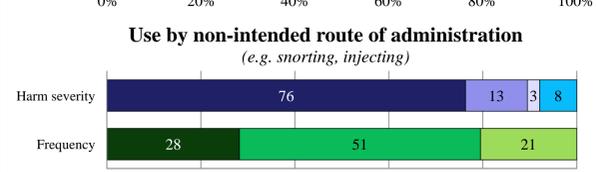
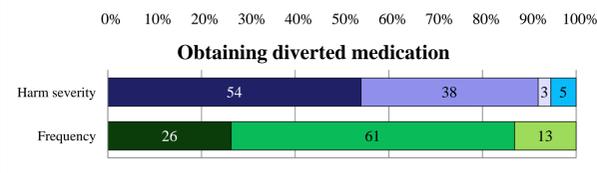
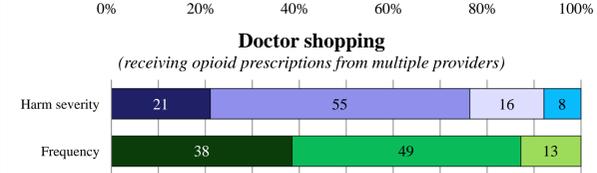
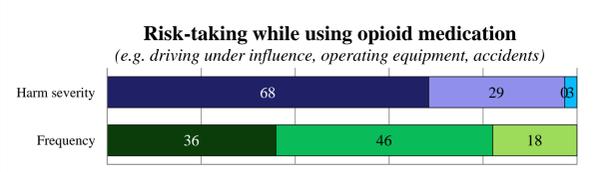
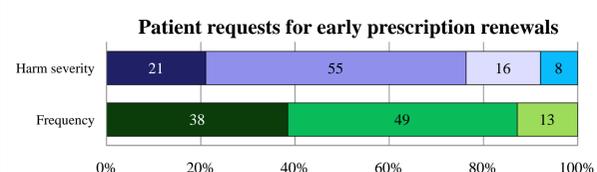
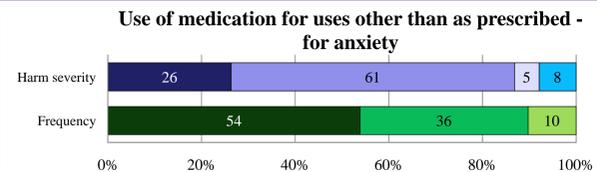
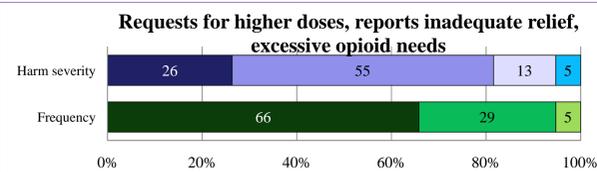
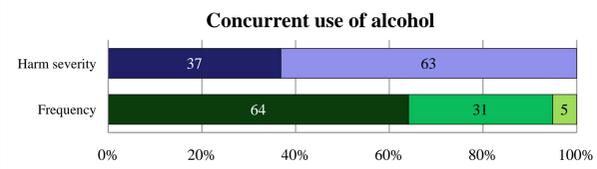
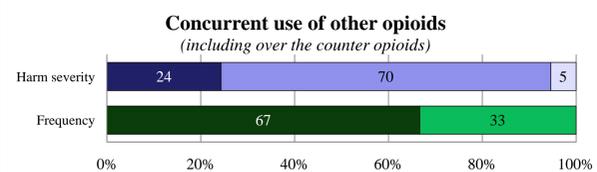
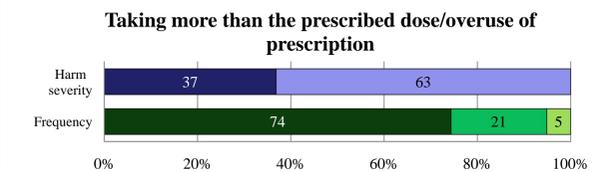
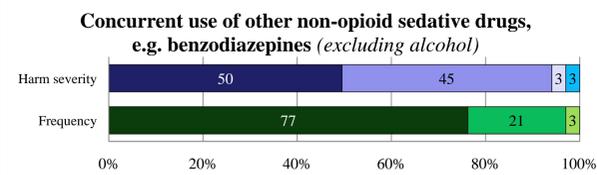
To develop a new scale based on the literature and tailored to the Australian context, rather than validate an existing scale. The aim of the scale is to aid the clinician in identifying patients who may benefit from a treatment review.

## Results: Key Expert Survey

39 surveys have been conducted to date with n=28 doctors, n=1 CNC, n=3 hospital and n=2 retail pharmacists, n=2 psychologists and n=2 consumer reps. Doctors were primarily (but not exclusively) specialists in addiction or pain medicine. n=30 were currently or had previously been involved in providing opioid substitution treatment.

KEs were asked to rate the 34 behaviours and related issues identified in the literature search in addition to others suggested by experts in terms of (i) frequency and (ii) perceived degree of potential harm to the patient; some of these are shown below:

Harm severity: ■ Extremely harmful ■ Somewhat harmful ■ Not harmful ■ N/A  
Frequency: ■ Frequently ■ Occasionally ■ Never/almost never



## Experience with administering measures to assess 'aberrant' behaviours relating to pharmaceutical opioid use

- Mixed levels of familiarity with existing scales; those mentioned were the DIRE, SOAPP-A and the ORT.
- Many were unaware of existing scales, and very few used any routinely.
- "Would you use such a scale to assist you in your clinical practice?" question responses were: n=16 'yes', n=7 'no' and n=15 'unsure'.
- Generally confident in ability to assess the risk of clients/patients engaging in 'aberrant' opioid related behaviours, with n=5 stating that they were 'extremely' and n=23 'fairly' confident; while n=6 were 'neither confident nor unconfident', n=3 were 'fairly unconfident' and n=1 was 'extremely unconfident'.
- This is likely to reflect the high proportions of respondents with expertise in pain management and opioid dependence treatment, and may not extend among practitioners without this level of expertise.

## The next step: Patient Survey

- N=400 chronic opioid patients to be recruited between May-August 2011 from pharmacies, pain clinics and OST programs.
- Self complete survey has been developed by the investigators using the literature, key expert and advisory committee expertise.
- Contains 1 item per 'aberrant' behaviour or related issue (total of 38 opioid behaviour items); participant asked to rate the extent to which they endorse each item, e.g. 'I have taken less of my opioid medication than was prescribed' - very often, often, sometimes, hardly ever, never
- For each item, participants also asked "Would you talk to your doctor about this, if he/she asked you about it? yes/no"
- Other items include demographics, general health, use of medications, pain, opioid dependence, mental health and wellbeing, alcohol and other drug use, and quality of life.
- Responses to the 38 opioid behaviour items will be analysed using exploratory factor analysis to develop a brief scale (approx 10 items) for use by practitioners.

## Conclusion

- Many scales have been developed in the USA, none of which have been formally validated in Australia.
- None felt to be suitable in their current form; decision made to develop a scale for use in the Australian context.
- Key experts were generally fairly confident in their ability to assess the risk of their patients engaging in 'aberrant' behaviours.
- This is a likely reflection of the large number of specialists involved in pain management and OST.
- Need more participants from General Practice - scale most likely to be most useful in primary care.
- Currently targeting recruitment to obtain greater GP input.

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